Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DEC OF TEXAS, INC.
601 TEXAN TRAIL, SUITE 201
CORPUS CHRISTI, TEXAS 78411

Respondent Name
TPS JOINT SELF INS FUNDS

Carrier's Austin Representative Box
Box Number 11

MFDR Tracking Number
M4-11-1560-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claimant was seen by Dr. Charles W. Kennedy Jr. for a DDE. My office has faxed the report and HCFA 1500 to adjuster on 3 separate occasions to no avail. I spoke to bill review today and they advised me that they still do not have a bill for our date of service. Requesting your assistance in getting this DDE paid in full with interest."

Amount in Dispute: $1,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: A copy of dispute was placed in carrier rep box on January 27, 2011 with no response to MFDR.

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 23, 2010	99456-W5-WP and 99456-RE-W6	$1,000.00	$1,000.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

No Explanation of Benefits provided by either party.

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor alleges that the respondent did not respond to its request for reconsideration. There was no documentation found to support that the carrier responded to the provider's initial bill or request for reconsideration with an EOB. There is also no response to MFDR regarding denial of disputed services. The Division will proceed with this review per applicable fee guidelines and will make its determination with the available documentation.
2. The provider billed the amount of $500.00 for CPT code 99456-W5-WP for DD Examination for Maximum Medical Improvement (MMI) and Impairment Rating (IR). Review of the documentation supports that MMI was assigned and one body area was given an IR. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. To determine reimbursement for an IR, the method of calculating IR and the number of body areas/conditions is reviewed. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I), the MAR for an IR using Diagnosis Related Estimates (DRE) Category 2 method on the lumbar (spinal region) is $150.00. The combined MAR for the MMI/IR exam is $500.00. The requestor (DD) also billed $500.00 for CPT code 99456-RE-W6 for an Extent of Injury (EXT) examination. Review of documentation supports that the Division ordered the examinations. Per 28 Texas Administrative Code §134.204(i)(2)(A) & (k), the Maximum Allowable Reimbursement (MAR) for the 1st Return to Work (RTW) and/or Evaluation of Medical Care (EMC) examination is $500.00. The combined MAR for the EXT and MMI/IR examinations is $1,000.00. Reimbursement in the amount of $1,000.00 is therefore recommended.

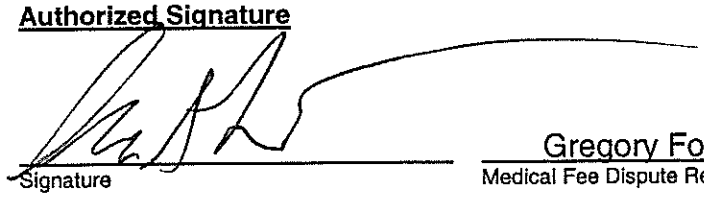
Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $1,000.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,000.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature



Signature | Gregory Fournerat, Medical Fee Dispute Resolution Officer | November 10, 2011, Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.